PSYCHIATRIC BRIEFS

EDITOR'S NOTE

This column reflects our commitment to provide you, the primary care physician, with information that will prove helpful in making informed decisions about the care of your patients who suffer from psychiatric disorders. We will highlight abstracts of high interest to you from our sister publication, *The Journal of Clinical Psychiatry*, and summarize pertinent articles from the general scientific literature. We hope that this section is clinically relevant to your practice and that it will encourage you to expand your horizons.

Mental Disorders in a Forensic Sample of Sexual Offenders

Leue A, Borchard B, Hoyer J

Background: The objective of this study was to examine the prevalence of DSM-IV Axis I disorders and DSM-IV personality disorders among sexual offenders in forensic state hospitals in Germany. **Method:** On the basis of clinical and structured interviews, current and lifetime prevalence rates of mental disorders were investigated among sexual offenders (N = 55). Subgroups were analyzed according to diagnostic research criteria: 30 sexual offenders were classified as paraphiliacs and 25 sexual offenders were diagnosed with impulse control disorder (without paraphilia). **Results:** Anxiety disorders, mood disorders, substance use disorders, and cluster B and C personality disorders were common among sexual offenders. Major depression was most prevalent in sexual offenders with impulse control disorder, while social phobia was most common among paraphilic sexual offenders. **Conclusion:** The results duplicate recent findings of high psychiatric morbidity in sexual offenders placed in forensic facilities. Differential patterns of comorbid mental disorders were found in paraphiliacs and impulse control disordered sexual offenders. In regard to effective therapy and relapse prevention, comorbid mental disorders should be a greater focus in the evaluation of subgroups of sexual offenders.
(Eur Psychiatry 2004;19:123–130)

A History of Major Depressive Disorder Influences Intent to Die in Violent Suicide Attempters

Astruc B, Torres S, Jollant F, et al.

Background: The inconsistency of the results obtained in biological studies of suicidal behavior may be due to the use of broad categories lacking validity. In previous genetic studies, in which we identified an association between a serotonin-related gene and violent suicide attempts, we suggested that a history of major depressive disorder (MDD) might influence this association. In this study, we aimed to clarify the relationships between the violence of suicide attempts, intent to die, and depression in a large sample of suicide attempters. **Method:** We investigated intent to die, according to history of violent suicide attempts and MDD, in 502 consecutively admitted suicide attempters. We characterized patients in terms of lifetime DSM-IV Axis I diagnoses, suicidal intent (Beck Suicide Intent Scale), and history of violent suicide attempts. **Results:** Suicidal intent, for both the last suicide attempt before admission and the most lethal suicide attempt, was higher in those with history of MDD (p = .03 and p = .04, respectively) but was not affected by history of violent suicide attempt. In violent suicide attempters, suicidal intent was higher in patients with a history of MDD than in patients with no such history (p = .04 for last suicide attempt and p = .02 for most lethal attempt), whereas MDD had no effect on suicidal intent in nonviolent suicide attempters. **Conclusion:** Violent suicide attempters constitute a heterogeneous group in terms of suicidal intent. Our results suggest that biological and genetic studies should take into account the method used to attempt suicide, intent to die, and history of MDD.
(J Clin Psychiatry 2004;65:690–695)

Anger Attacks in Bipolar Depression: Predictors and Response to Citalopram Added to Mood Stabilizers

Mammen OK, Pilkonis PA, Chengappa KNR, et al.

Background: Of the 2 reports in the literature on anger attacks in bipolar depression, one found them to be uncommon (12%) compared with the rate in bipolar mixed states and unipolar depression (40%–60%), whereas the other found them to be common (62%). We examined anger attacks among participants in an 8-week trial of open-label citalopram added to mood stabilizer for the treatment of bipolar depression. We also examined trait anger, hypomanic symptoms, and depressive symptoms as predictors of anger attacks. We hypothesized that if

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anger attacks were related to hypomanic symptoms they would respond unfavorably to citalopram, whereas if they were related to trait anger or depressive symptoms they would respond favorably. *Method:* In 45 participants with a DSM-IV diagnosis of bipolar I or II depression, anger attacks, hypomanic symptoms, and depressive symptoms were assessed using a modified Anger Attacks Questionnaire, Young Mania Rating Scale, and Hamilton Rating Scale for Depression, respectively. Trait anger was measured using the State-Trait Anger Inventory. Posttreatment data were collected at the end of 8 weeks of treatment with citalopram or at dropout from the trial. The first participant study visit was in November 1998, and the final participant study visit was in December 2000. *Results:* Before treatment with citalopram, 17 (38.6%) of 44 participants reported anger attacks (data on anger attacks were missing for 1 participant before treatment and 4 after treatment). Significantly fewer participants reported anger attacks after treatment (6 of 41, 14.6%; McNemar test, p < .05, 2-tailed). At pretreatment and posttreatment, trait anger was the only significant predictor of anger attacks (p < .05). *Conclusions:* These findings suggest that in bipolar depression anger attacks are common, may respond favorably to acute treatment with citalopram added to mood stabilizer, and are better predicted by trait anger than hypomanic or depressive symptoms. Further studies are needed to clarify the diagnostic and treatment implications of anger attacks in bipolar depression.

(J Clin Psychiatry 2004;65:627–633)

Anxiety After Miscarriage: A Review of the Empirical Literature and Implications for Clinical Practice

Brier N

Background: A miscarriage is viewed by most practitioners as a significant psychosocial stressor resulting in a high level of grief and dysphoria. Although also commonly present, anxiety is less frequently considered and addressed. The authors conducted a review of the empirical literature to determine if anxiety after a miscarriage is elevated and if risk is increased for particular types of anxiety syndromes. An attempt was also made to identify the types of interventions that have been found to be helpful in alleviating anxiety. *Method:* The MEDLINE and PSYCHINFO databases were searched using the keywords *miscarriage*, *perinatal loss*, *pregnancy loss*, *anxiety*, *trauma*, and *stress*. The searches were not intentionally restricted by date. References were utilized for further searches. Studies were subsequently included only if most women in a study sample experienced the pregnancy loss before 20 weeks' gestation. *Results:* The literature was relatively limited. In regard to level of anxiety after a miscarriage, 4 studies were located that employed a matched comparison group design, and 3 that employed a follow-up design. With respect to an increased risk for particular anxiety syndromes, 3 studies that used a matched comparison design were located. Many women experience elevated levels of anxiety after a miscarriage up until about 6 months post-miscarriage. These women are at increased risk for posttraumatic stress and obsessive-compulsive disorders. *Conclusions:* As part of routine care after a miscarriage, practitioners should screen for signs of anxiety and depression. Opportunities for understanding, catharsis, and legitimation will most likely be helpful when signs of anxiety are present, as is reassurance that the stress will probably lessen considerably over the next 6 months.

(Birth 2004;31:138–142)

Depressive Symptoms and Health Risk Among Rural Adolescents

Burns JJ, Cottrell L, Perkins K, et al.

Background: The objective of this study was to determine the stability of depression and its relationship with health risk factors among rural adolescents. *Method:* Participants (N = 64) who attended a rural, primary care, adolescent medicine clinic were tested for depression and risk factors in this clinic-based longitudinal study. The Perkins Adolescent Risk Screen (PARS) was the primary measure of risk and depression. Patients aged 12 to 18 years who had completed PARS assessment during previous visits to the clinic were invited to complete a follow-up assessment. *Results:* The mean age of adolescents was 12.79 years at baseline and 14.59 years at follow-up. Adolescent depression and various adolescent risk indices were significantly related at baseline, with age and gender being controlled. Longitudinally, baseline depression scores on PARS were related to risk behaviors/factors at follow-up including depression, school problems, substance abuse, tobacco use, sexual activity, and violent behavior scores and a history of physical/sexual abuse. On multivariate analysis controlling for other significantly associated variables, the relationship persisted for baseline depression and follow-up measures including tobacco, substance abuse, depression, and history of physical/sexual abuse. *Conclusion:* A strong longitudinal relationship was confirmed between baseline depressive symptoms and several important risk behaviors/factors measured at follow-up in this clinic-based study of rural adolescents. Longitudinal stability of depression over time was also supported.

(Pediatrics 2004;113:1313–1320)

Risk for Cancer in Parents of Patients With Schizophrenia

Dalton SO, Laursen TM, Mellemkjaer L, et al.

Background: The purpose of this study was to determine whether parents of offspring with schizophrenia might manifest a genetic protection against cancer. *Method:* The authors identified 1,999,072 parents of offspring born after 1935 using data from the Danish Central Population Registry. This nationwide population-based parent cohort was linked to the Danish Psychiatric Central Register, and 19,856 parents of offspring with schizophrenia were identified. Follow-up for cancer in the Danish Cancer Registry began on the date of birth of the oldest child or April 1, 1969, and ended on the date of cancer diagnosis, death, or Dec. 31, 1997, yielding 48,343,430 person-years at risk and 211,681 cases of cancer. The relative risk for cancer among parents with no schizophrenic offspring compared with parents with schizophrenic offspring was estimated by Poisson regression analysis adjusted for age, period, and number of children. *Results:* The risk for all cancer was 1.00 for mothers and 1.01 for fathers of schizophrenics. An increased risk of 1.20 for lung cancer and a nonsignificant risk of 1.14 for tobacco-related cancers combined was found for mothers of schizophrenics. There was no difference in risk for any other cancer, with the exception of a reduced risk for leukemia in both mothers and fathers of schizophrenics. *Discussion:* This study provides no support for genetic protection again cancer in families with schizophrenia and does not confirm a previously reported reduced risk for cancer in parents of schizophrenic patients.

(Am J Psychiatry 2004;161:903–908)

What Characteristics of Primary Anxiety Disorders Predict Subsequent Major Depressive Disorder?

Bittner A, Goodwin RD, Hans-Ulrich Wittchen HU, et al.

Objective: The goal of this study was to examine the associations between specific anxiety disorders and the risk of major depressive disorder and to explore the role of various clinical characteristics of anxiety disorders in these relationships using a prospective, longitudinal design. ***Method:*** The data are from a 4-year prospective, longitudinal community study, which included both baseline and follow-up survey data on 2548 adolescents and young adults aged 14 to 24 years at baseline. DSM-IV diagnoses were made using the Munich-Composite International Diagnostic Interview. ***Results:*** The presence at baseline of any anxiety disorder (odds ratio [OR] = 2.2 [95% CI = 1.6 to 3.2]) and each of the anxiety disorders (specific phobia, OR = 1.9 [95% CI = 1.3 to 2.8]; social phobia, OR = 2.9 [95% CI = 1.7 to 4.8]; agoraphobia, OR = 3.1 [95% CI = 1.4 to 6.7]; panic disorder, OR = 3.4 [95% CI = 1.2 to 9.0]; generalized anxiety disorder, OR = 4.5 [95% CI = 1.9 to 10.3]) was associated with a significantly (p < .05) increased risk of first onset of major depressive disorder. These associations remained significant after we adjusted for mental disorders occurring prior to the onset of the anxiety disorder, with the exception of the panic disorder association. The following clinical characteristics of anxiety disorders were associated with a significantly (p < .05) increased risk of developing major depressive disorder: more than 1 anxiety disorder, severe impairment due to the anxiety disorder, and comorbid panic attacks. In the final model, which included all clinical characteristics, severe impairment remained the only clinical characteristic that was an independent predictor of the development of major depressive disorder (OR = 2.2 [95% CI = 1.0 to 4.4]). ***Conclusion:*** Our findings suggest that anxiety disorders are risk factors for the first onset of major depressive disorder. Although a number of clinical characteristics of anxiety disorders appear to play a role in the association between anxiety disorders and depression, severe impairment is the strongest predictor of major depressive disorder.

(J Clin Psychiatry 2004;65:618–626)

Quality of Care for Medicaid-Covered Youth Treated With Antidepressant Therapy

Richardson LP, DiGiuseppe D, Christakis DA, et al.

Background: Few studies have addressed the quality of follow-up care or duration of treatment for depressed youth, although antidepressant use has increased in pediatric populations. The objective of this study was to evaluate the quality of care for antidepressant-treated youth using the Health Plan Employer Data and Information Set guidelines as a benchmark (≥ 3 visits in the 3 months following a new antidepressant prescription fill and continuation of antidepressant use at 3 and 6 months). ***Method:*** Administrative records of 1205 Medicaid-covered youth (aged 5–18 years) who presented with a new episode of depression in 1998 were examined. Statistics were generated to depict the number of follow-up visits and duration of treatment within 6 months of the first prescription fill. ***Results:*** Antidepressants were used to treat 42.1% (N = 507) of youth with new episodes of depression. Selective serotonin reuptake inhibitors accounted for 80.9% of prescriptions. Of youth with an antidepressant fill, 28.1% had 3 or more follow-up visits in the subsequent 3 months; an additional 29.2% had no further visits.

Treatment with selective serotonin reuptake inhibitors were continued by 46.6% of youth at 3 months and by 26.3% at 6 months. ***Conclusions:*** Many youth treated with antidepressants do not receive adequate duration of treatment or follow-up. Reasons for poor follow-up and methods to improve monitoring for these youth should be explored in future studies.

(Arch Gen Psychiatry 2004;61:475–480)

Community-Integrated Home-Based Depression Treatment in Older Adults: A Randomized Controlled Trial

Ciechanowski P, Wagner E, Schmaling K, et al.

Background: Older adults with social isolation, medical comorbidity, and physical impairment are more likely to be depressed but may be less able to seek appropriate care for depression than older adults without these characteristics. The objective of this study was to determine the effectiveness among older adults of a home-based program for detecting and managing minor depression or dysthymia. ***Method:*** The study was a randomized controlled trial with recruitment through community senior service agencies from January 2000 to May 2003 in metropolitan Seattle, Wash. Subjects included 138 patients aged 60 years or older with minor depression (51.4%) or dysthymia (48.6%). Patients had a mean of 4.6 (SD = 2.1) chronic medical conditions. Patients in the sample had the following characteristics: 42% belonged to a racial/ethnic minority, 72% lived alone, 58% had an annual income of less than $10,000, and 69% received a form of home assistance. Patients were randomly assigned to the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) intervention (N = 72) or usual care (N = 66). The PEARLS intervention consisted of social and physical activation, potential recommendations to patients' physicians regarding antidepressant medications, and problem-solving treatment. Main outcome measures were assessments of depression and quality of life at 12 months compared with baseline. ***Results:*** In comparison with the usual care group, at 12 months those patients receiving the PEARLS intervention were more likely to have at least a 50% reduction in depressive symptoms (43% vs. 15%; odds ratio [OR] = 5.21; 95% CI = 2.01 to 13.49), to achieve complete remission from depression (36% vs. 12%; OR = 4.96; 95% CI = 1.79 to 13.72), and to have greater health-related quality-of-life improvements in functional well-being (p = .001) and emotional well-being (p = .048). ***Conclusions:*** PEARLS, a community-integrated, home-based treatment for depression, significantly reduced depressive symptoms and improved health status in chronically medically ill older adults with minor depression and dysthymia.

(JAMA 2004;291:1569–1577)

Childhood Abuse and Risk of Eating Disorders in Women

Rayworth BB, Wise LA, Harlow BL

Background: Eating disorders are one of the most common psychiatric disorders among women; however, very little is known about underlying causes. ***Method:*** The authors performed a case-control study of women participating in the Harvard Study of Moods and Cycles, a population-based sample of women aged 36 to 44 years, to assess the association

between childhood violence victimization and eating disorders. Cases included women who met the DSM-IV diagnostic criteria for anorexia nervosa, bulimia nervosa, or binge-eating disorder after a structured clinical interview. History of abuse as a child was assessed with a self-administered questionnaire. ***Results:*** Women who reported childhood physical abuse had twice the odds of suffering from subclinical eating disorder symptoms (odds ratio [OR] = 2.0; 95% CI = 1.3 to 3.3) or meeting DSM-IV criteria for an eating disorder (OR = 2.1; CI = 1.1 to 4.2), compared with women who reported no abuse. Women who reported both physical and sexual abuse during childhood had 3 times the odds of developing eating disorder symptoms (OR = 3.0; CI = 1.3 to 6.8) and nearly 4 times the odds of meeting DSM-IV criteria for an eating disorder (OR = 3.9; CI = 1.3 to 11.5). Within the subgroup of women with no depression antecedent to first onset of an eating disorder, these associations persisted. ***Conclusions:*** This study provides additional evidence of an association between preadolescent trauma and psychiatric morbidity.

(Epidemiology 2004;15:271–278)

Five-Year Impact of Quality Improvement for Depression: Results of a Group-Level Randomized Controlled Trial

Wells K, Sherbourne C, Schoenbaum M, et al.

Background: Health outcomes for depressed primary care patients can improve for 6 to 28 months with quality improvement (QI) programs. Effects for longer than 28 months, however, are unknown. This study assessed how QI for depression affects health outcomes, quality of care, and health outcome disparities at 57-month follow-up. ***Method:*** Forty-six primary care practices in 6 managed care organizations were included in this group-level randomized controlled trial. Of 1356 primary care patients who screened positive for depression and enrolled in the trial, 991 (73%, including 451 Latinos and African Americans) completed 57-month telephone follow-up. Clinics were randomly assigned to usual care or to 1 of 2 QI programs supporting QI teams, provider training, nurse assessment, and patient education, plus resources to support medication management (QI-meds) or psychotherapy (QI-therapy) for 6 to 12 months. The main outcome measures included probable depressive disorder in the previous 6 months, mental health-related quality of life in the previous 30 days, counseling or antidepressant medications in the previous 6 months, primary care or mental health specialty visits, and unmet need, defined as depressed but not receiving appropriate care. ***Results:*** Relative to usual care, combined QI-meds and QI-therapy reduced the percentage of participants with probable disorder at 5 years by 6.6 percentage points (p = .04). Health outcomes improved and unmet need for appropriate care among Latinos and African Americans combined was reduced with QI-therapy. Long-term benefits among whites were few, reducing outcome disparities related to usual care (p = .04 for QI-ethnicity interaction for probable depressive disorder). ***Conclusions:*** Quality improvement programs for depressed primary care patients implemented by managed care practices improved health outcomes 5 years after implementation. The programs also reduced health outcome disparities by markedly improving health outcomes and unmet need for appropriate care among Latinos and African Americans relative to whites; thus, equity was improved in the long run.

(Arch Gen Psychiatry 2004;61:378–386)

Risperidone in the Treatment of Delirium: Results From a Prospective Open-Label Trial

Mittal D, Jimerson NA, Neely EP, et al.

Background: Effective treatment is necessary to reverse delirium and prevent potentially serious consequences. ***Method:*** Patients were identified for screening by initial chart review of all consecutive admissions to the general medical or surgical wards at the Department of Veterans Affairs hospital and the University of Mississippi Medical Center in Jackson, Miss., between November 2000 and April 2002. Medically ill patients with delirium defined by DSM-IV criteria and a Delirium Rating Scale (DRS) score of ≥ 13 were given risperidone, 0.5 mg, twice daily, with additional doses permitted on day 1 for target symptoms. Total day 1 dosage was given daily until the DRS score was ≤ 12; dosage was then decreased by 50% (maintenance dose) and continued until day 6. Daily assessment included DRS, Cognitive Test for Delirium (CTD), and modified Extrapyramidal Symptom Rating Scale. Functional status (Karnofsky Scale of Performance Status; KSPS) and medical burden (Cumulative Illness Rating Scale) were assessed at baseline and day 6. ***Results:*** Ten patients (mean age = 64.7 years) were enrolled. Mean daily maintenance risperidone dosage was 0.75 mg. Mean CTD scores improved from day 1 to the day maintenance dose was initiated (p < .0005) and remained improved at day 6 (7.1 ± 2.0 and 16.9 ± 3.0, days 1 and 6, respectively; p = .0078). Mean DRS scores improved from day 1 to the day maintenance dose was initiated (p < .0001) and remained improved at day 6 (25.2 ± 0.9 and 11.3 ± 1.5, days 1 and 6, respectively; p < .0001). Mean KSPS scores improved from 32.0 on day 1 to 45.5 on day 6 (p = .044). No patient developed movement disorders. One patient each discontinued because of sedation and hypotension. ***Conclusion:*** Low-dose risperidone can improve cognitive and behavioral symptoms of delirium in medically ill patients.

(J Clin Psychiatry 2004;65:662–667)

Augmentation of Serotonin Reuptake Inhibitors in Refractory Obsessive-Compulsive Disorder Using Adjunctive Olanzapine: A Placebo-Controlled Trial

Bystritsky A, Ackerman DL, Rosen RM, et al.

Background: The purpose of this study was to explore the efficacy of adding an atypical antipsychotic, olanzapine, to a serotonin reuptake inhibitor (SRI) in treatment-refractory obsessive-compulsive disorder (OCD). ***Method:*** Twenty-six patients aged between 18 and 65 (mean = 41.2, SD = 11.9) years meeting DSM-IV criteria for OCD, who had not responded to SRIs, were treated for 6 weeks in a double-blind, placebo-controlled augmentation study with either olanzapine (up to 20 mg/day) or placebo. Severity of illness was assessed biweekly by the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). Analysis of covariance with baseline Y-BOCS score included as a covariate was used to compare improvement in Y-BOCS scores in the 2 groups. Response was defined as a 25% or greater improvement in Y-BOCS score. Data were collected between April 2001 and May 2003. ***Results:*** Outcome was assessed for all patients using the last observation carried forward. Subjects in the olanzapine group had a mean decrease of 4.2 (SD = 7.9) in Y-BOCS score compared with a mean increase in score of 0.54 (SD = 1.31) for subjects in the placebo group (F = 4.85, df = 2,23; p = .04). Six (46%) of 13 subjects in the

olanzapine group showed a 25% or greater improvement in Y-BOCS score compared with none in the placebo group. The final mean dose of olanzapine was 11.2 (SD = 6.5) mg/day. Medication was well tolerated. Only 2 (15%) of 13 subjects who received olanzapine discontinued because of side effects: sedation (N = 1) or weight gain (N = 1). ***Conclusion:*** These results provide preliminary evidence that adding olanzapine to SRIs is potentially efficacious and well tolerated in the short-term treatment of patients with refractory OCD. Controlled studies with larger sample sizes are necessary to more definitively address this treatment strategy.

(J Clin Psychiatry 2004;65:565–568)

How Effective Is St. John's Wort? The Evidence Revisited

Werneke U, Horn O, Taylor DM

Background: St. John's wort (*Hypericum perforatum*) has been identified as an effective treatment for depression in controlled studies and subsequent meta-analyses. However, 3 recently published large studies failed to demonstrate robust efficacy. Updated meta-analysis and assessment of publication bias may help determine the true effect of St. John's wort. ***Method:*** Meta-analysis to reevaluate the effectiveness of St. John's wort as an antidepressant, funnel plot analysis, and meta-regression to assess the impact of publication bias, small-study effects, and variation in trial characteristics were performed. We conducted 2 analyses: a reproduction of a recent meta-analysis including 15 studies (Meta-15) and a meta-analysis extended by the 3 studies published since then (Meta-18). The studies in Meta-15 were identified through MEDLINE and EMBASE searches conducted in June 2000. The search terms used were *St. John's wort, hypericum, hypericin, depression,* and *antidepressant,* and no language restrictions were applied. For both meta-analyses, we compared funnel plots, Begg's rank correlation, Egger's regression, trim and fill method, and meta-regression. ***Results:*** In both analyses, effect sizes in recent studies were smaller than those reported in earlier studies; the addition of more recent studies into the analyses resulted in reduced effect size. In Meta-15, St. John's wort was significantly more effective than placebo with a risk ratio (RR) of 1.97 (CI = 1.54 to 2.53). In Meta-18, the RR was reduced to 1.73 (CI = 1.40 to 2.14). On funnel plot analysis, the Meta-18 plot proved to be much more skewed than the Meta-15 plot. Meta-regression showed that increase in effect size was associated with smaller sample size only. The impact of baseline severity of depression could not be evaluated as the studies used different versions of the Hamilton Rating Scale for Depression. ***Conclusion:*** St. John's wort may be less effective in the treatment of depression than previously assumed and may finally be shown to be ineffective if future trials confirm this trend.

(J Clin Psychiatry 2004;65:611–617)